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Expertise in action: Insights into the dynamic nature of expertise in community-based nursing

Caroline A.W. DICKSON\*

Senior Lecturer in Community Nursing, Queen Margaret University

DHSSc, RN, Dip DN

Chris McVITTIE

Professor of Social Psychology, Queen Margaret University

PhD, CPsychol, AFBPsS

Anuj KAPILASHRAMI

Lecturer in Global Health Policy, University of Edinburgh

PhD, MSc (Reproductive & Sexual Health), MA (Sociology)

\*Correspondence to: \*Correspondence to: Dr. Caroline Dickson, Senior Lecturer, Division of Nursing, School of Health Sciences, Queen Margaret University, Edinburgh EH21 6UU.  
[cdickson@qmu.ac.uk](mailto:cdickson@qmu.ac.uk)

Tel: 0131 474 0000

Twitter @cawdickson

## Abstract

**Aim:** To gain insight into community nurses' experiences and how they make sense of the expertise they offer in their role

**Background:** Globally, the spotlight is currently on community nursing expertise because of the movement of hospital-based to community-based care. Caring for people at home is no longer solely concerned with prevention, but delivering complex care to patients who are acutely unwell or at the end of their life. Little is known about the distinct expertise of community nurses, or their contribution to patient outcomes. There is a need to examine expertise in this group in order to inform current and future care provision within community settings.

**Design:** A hermeneutic, phenomenological study.

**Method:** Semi-structured interviews were conducted with eight community nurses in Scotland, UK, who hold an additional post-registration, professional qualification. Participants also kept audio-journals. Data were analysed using Interpretive Phenomenological Analysis.

**Findings:** Participants described their expertise in three themes; negotiating a 'way in' to care, managing complexity, and 'thinking on your feet'. They did not refer to themselves as specialist practitioners, nor did they perceive that they were viewed as specialist by colleagues or management. They appeared to dismiss their range of expertise which included forming trusting relationships, anticipating care needs and problem-solving, enabling them to undertake complex care management.

**Conclusions:** Expertise of community nurses in this study is dynamic, contextualised and action-oriented enabling them to be creative problem-solvers. It reflects engagement with patients and families and all aspects of the setting where care is provided, rather than being solely an identifiable set of specialist skills,

**Relevance to clinical practice:** It is vital to recognize community-based expertise internationally, especially if current WHO aims for community-based health care are to be achieved. Highlighting this expertise contributes to current discourse and may be considered in education and practice reviews.

**Key words:** *community nursing, district nursing, specialist, expertise, problem-solving, anticipatory care*

What this paper adds

Uses Interpretive Phenomenological Analysis to understand nuances of community nursing expertise

Identifies key aspects of community-based nurses' expertise that contribute to current political strategy of avoiding unnecessary hospital admissions.

Understanding expertise will inform nursing curricula both pre- and post-registration

author accepted version

## Introduction

Globally there is an increasing focus on nursing within the community due to a re-orientation of health services across the developed world, towards caring for people in their own homes and avoiding unnecessary hospital admissions (Department of Health (DH) 2014; World Health Organization (WHO) 1999; 2013; 2016). The changing demographics found in many countries are manifested in ageing populations with care needs arising from frailty, long-term conditions and greater numbers of individuals being at end of life. There is now recognition that primary and community care is no longer solely concerned with prevention (Maybin, Charles, Honeyman 2016). There is a move to provide the necessary care for acutely ill patients and those who choose to die at home. At the same time, economic challenges also emphasise the importance of delivering care in the community where possible, reducing the pressures on high-cost hospitalised care. The role of nurses working in the community is therefore increasingly important.

A key element in moves towards increased nursing in the community has been an emphasis on the distinct expertise that community-based nurses can bring to providing healthcare in such settings (WHO, 2010). For example, WHO's Framework for Community Health Nursing Education highlights that those who are to undertake such provision should learn from experts in 'real-life community health care' (WHO, 2010p.23). The question of precisely what such expertise comprises however, and how it is learned, is far from settled. We examine here the understandings of one specific group of nurses involved in delivering care in community settings in order to explore what expertise comprises, and offer a further contribution to understanding of nursing expertise in community contexts.

## Nursing and expertise

The question of how expertise in nursing is to be understood has long been a matter of debate. Elsewhere expertise has often been described in terms of cognitive structures within a context of a wide range of knowledge that enable experts to pick up subtle cues which may be missed by novices (Schunn, McGregor & Saner, 2005; Kotzee 2014). Drawing inferences based on particular forms of knowledge as instrumental to expertise, is also cited, as is the application of highly-developed reasoning strategies that are not available to novices (Chi, Feltovich & Glaser, 1988; Boshuizen & Schmidt, 2008).

Such views of expertise have been taken up to some extent in the nursing literature, with, for example, various writers arguing that expertise is dependent upon perceptual learning and acquired perceptual skills as demonstrated in deliberative practice (Cioffi 2013; Kellman & Garrigan 2009). Other writers, by contrast, have proposed somewhat different versions of nursing expertise, based on nursing as a model of practical action involving '*knowing that*' and '*knowing how*' (Benner 1984; Rolfe 1998). Manley, Hardy, Titchen, Garbett, and McCormack (2005) refer to nursing expertise as professional artistry enabled through holistic practice knowledge. One reason for this divergence of views is that nursing expertise has often been viewed as being based on intuition and is consequently difficult to articulate (Benner 1984; Rolfe 1998). Thus expertise is commonly taken to be tacit or opaque (Meerabeau 1992; Herbig, Büssing & Ewert 2001), with an expert being seen as someone who 'knows more than they can tell' (Kinchin, Cabot & Hay 2008, p.93). The outcome, however, of the diverse conceptualisations of expertise found across the nursing literature has been that after 30 years there is little consensus on the nature of the phenomenon. There is even less consensus on how it

might be recognised (Hutchinson, Higson, Cleary & Jackson 2016, p. 292). Thus, following an analysis of related literature, Hutchinson et al. (2016) argue that for the concept of expertise to be relevant to contemporary nursing and the diversity of activities in which nurses now engage, it requires further development and reconsideration of what has to date been taken-for-granted. Perhaps nowhere is development more needed than in relation to the current re-orientation of health services across the globe to community contexts.

### **Nursing in the community: global issues**

A lack of consensus as to what expertise comprises, presents one obstacle to providing nursing care in the community. This is by no means the only challenge. Many researchers have noted the difficulties encountered in seeking to attract nurses to work in a range of community settings (Efendi, Purwaningsih, Kurniati & Bushy, 2014; Njuguna, Mwangi & Kamau, 2014; Onnis & Pryce, 2016) as well as the difficulties in actually recruiting nurses who are suitably equipped to engage fully in community-based initiatives (Jaskiewicz & Deussom, 2014). Equally challenging is the retention of nurses in community settings, with rates of attrition high, especially in areas that are geographically remote or rural (Fadi El-Jardali, Murray, Dimassi, Jamal, AbuAlRub, Al-Surimi, Clinton & Dumit, 2013; Keane, Lincoln, Rolfe & Smith, 2013; Russell, McGrail & Humphreys, 2017). Often nurses working in such contexts cite geographical locations and related factors, such as poor transportation and lack of supportive infrastructure, as reasons for seeking to leave community-based nursing (AbuAlRub, El-Jardali, Jamal, Iblasi & Murray, 2013; El-Jardali, Alameddine, Dumit, Dimassi, Jamal. & Maaloufa, 2011; Nowrouzi, Rukholm, Lariviere, Carter, Koren, Mian & Giddens, 2016). All such work has been useful in pointing to the issues that are commonly encountered in particular settings like lack of support and career

development. Rather less attention, however, has been paid to other elements involved in providing nursing in the community. As the workforce has consistently referred to as ‘invisible’ in professional discourse and literature (QNI 2002; 2006; Wood 2012; Maybin, Charles, Honeyman 2016) there is a need to understand more about community nursing work. This might go some way to addressing issues faced by this sector of the profession.

### **Nursing in the community: the UK context**

Recruitment and retention of nurses in the community is a major challenge within UK healthcare. Currently in the UK, the role title given to community nurses who care for ill adults at home is that of District Nurse (DN), with around 2% of the total National Health Service (NHS) budget being allocated to district nursing (DH 2015). In order to gain the title and practice as a DN, an additional post-registration programme of study is required and the qualification is also recorded on a professional register and affords nurses the role title: Specialist Practitioner District Nurse (SPDN) (Nursing and Midwifery Council (NMC) 2001). Specialist Practitioner District Nurses reportedly use specialist and technical expertise (Queens Nursing Institute (QNI) 2014; Royal College of Nursing (RCN) 2013; Maybin, Charles, Honeyman 2016) to provide care in a variety of community settings. Interventions range from fundamental caring, wound and pain management and end of life care, to more technical care involving intravenous therapy including chemotherapy, prescribing and home ventilation (Maybin, Charles, Honeyman 2016). In the UK, comprehensive high quality district nursing services are considered to have the potential to reduce use of hospital sector and residential social care through a variety of means: Leading care, helping people to recover from episodes of ill health or following injury,



safeguarding adults from vulnerability and harm thus ensuring people have positive experience of care, enhanced quality of life and can be prevented from dying prematurely (DH 2014)

According to the NMC (2001 p4) being a SPDN is concerned with '*higher levels of clinical judgment, discretion and decision-making in clinical care*' within four domains of practice: clinical nursing practice, care and programme management, clinical practice leadership and clinical practice development. The challenge is in whether these skills and attributes are translated in practice because few research studies identify DN participants as specialist practitioners in their findings. A number of studies describe the role as practical although SPDNs in the studies claimed their expertise was in case management and equal to identified case managers (O'Brien and Jack (2009; King et al 2010; Gage, Ting, Williams, Drennan, Goodman, Iliffe, Manthorpe, Davies & Masey, 2013). Chan, Laws, Williams, Davies, Fanaian, & Harris (2013) described district nursing services more broadly as reactive rather than proactive however, other studies have found that DNs actively use practical aspects or tasks to anticipate care needs, although specialization was not recorded (Cruikshank, Adamson, Logan & Brackenridge, 2010; Kennedy, Harbison, Mahoney, Jarvis & Veitch 2011). Wilhelmsson and Lindberg (2009) reported enabling self-management as an invisible aspect of the DN role whilst other studies have focused on care coordination following discharge, negotiating care packages and collaborating with out of hours services (O'Brien and Jack 2009; Cruikshank et al 2010; Wilkes, Cioffi, Cummings, Warne, & Harrison, 2013).

District nursing in the UK is however under pressure. While caseloads are increasing (RCN 2013; Maybin, Charles, A., Honeyman. 2016), the number of SPDNs is markedly decreasing.

Between 2001 and 2013, the number of SPDNs in England and Wales fell by 40% (Ball, Phillipou, Pike, & Sethi 2013; Information Centre for Health and Social Care 2014). This decrease may be due to various factors. One such factor is that some healthcare providers no longer view the SPDN qualification as a requirement to develop DN expertise, leading to reduced numbers supported to undertake the qualification. The decrease may also be due to increasing numbers of nurses with the SPDN qualification leaving the profession. In a survey carried out in England, Ball et al (2014) noted that the average age of SPDNs is 46 years and 35% were over the age of 50 years, suggesting that many SPDNs might have left or be about to leave on grounds of age. Findings also revealed many SPDNs wish to leave the profession on the grounds of dissatisfaction with their nursing experiences. Additionally, the survey found that nearly half of the respondents were dissatisfied with their role and 40% stated that if they could leave the profession they would do so. Reasons identified for dissatisfaction included poor staffing resulting in a lack of time to care for patients, inadequate skill-mix, and lack of IT support impacting on patient and staff well-being. A particular concern was a perceived lack of impact of the role on patient outcomes, consistent with the findings of a number of studies (Disler and Jones (2010; Kennedy, Harbison, Mahoney, Jarvis & Veitch,. 2011; Haycock-Stuart and Kean 2012; 2013).

The problems outlined above, relating to falling recruitment of SPDNs into the profession and increasing numbers leaving or seeking to leave community nursing, have resulted in a significant capacity and capability gap within district nursing in the UK (Maybin Charles, Honeyman 2016). Here we aim to extend previous work that has examined issues of invisibility of the role and potentially illuminate problems in role recruitment and retention of nurses in community

settings. Gaining insight into experiences of SPDNs working in the community in the UK, specifically how they make sense of the expertise that they offer will offer a contribution to current reviews of community nursing and educational preparation.

## **Methods**

### **Design**

The data for the present study come from a larger study that sought to examine more broadly the experiences and understandings of SPDNs. This qualitative study sought to explore how participants made sense of their experiences of being an SPDN, drawing on the theoretical framework of Interpretative Phenomenological Analysis (IPA). IPA as an approach allows for the development of theory through the detailed examination of individuals' own understandings of their experiences. It provides a means of gaining an 'insider perspective,' of experiences, within different work environments, important because of the impact of contexts on practice (Smith, Flowers and Larkin. 2009). IPA has its theoretical roots in phenomenology and hermeneutics and involves the researcher interpreting the participant's sense-making of '*being-in-context*'. (Heidegger 1995; Gadamer 2004; Smith and Osborn 2008). This is achieved through the hermeneutic circle where, according to Gadamer the truth is revealed through a flow of consciousness of '*prejudices*' or '*pre-understandings*' arising from history and traditions, together with current experiences of both participant and researcher. The theory derived from the application of IPA within a specific context is designed to reflect and synthesize the close detail of the understandings of individuals of 'being' in that context.

## Data collection

Within IPA studies, there is an intention to recruit participants who represent a particular perspective of the phenomenon (Smith 2007). Due to the idiographic nature of the approach, IPA in any instance relies on the recruitment of a small sample of participants to whom the research is immediately relevant and who can provide rich data to address the research question. The approach, therefore, seeks to elicit and interpret the detailed understandings of a small and specific set of individuals instead of aiming to produce outcomes that are generalizable to a population regardless of their own investment in the topic of study. For this study District Nurses working as SPDNs in one area in Scotland, UK, were recruited to the study via invitation from the Director of Nursing. Participants were selected purposively to achieve a homogenous group i.e. district nurses holding an SPQ. Eleven interested participants contacted the researcher for further information. Two did not meet the study inclusion criteria of holding an SPQ. One withdrew because of workload issues. Eight volunteered to take part and gave consent.

A meeting was arranged in a convenient location of participants' choosing within their practice area. Semi-structured interviews were conducted by the first author and guided by a series of open-ended questions inviting participants to tell their stories of their experiences of being SPDNs, their caseloads, knowledge and skills they used in practice, and the changes they had experienced during their DN careers. Each interview was between 45 and 75 minutes. Open-ended questions, previously piloted, were designed to probe into '*everydayness*' and to encourage dialogue. Overarching questions included for instance '*can you please share with me what it's like being a SPDN? Could you please tell me of a situation when you demonstrated specialist practice?*' Other more specific questions included, '*what do you think others value about your role?*' See Fig 1. Findlay (2003 p10) emphasizes approaching the interview with

‘openness and awe,’ thus enabling the researcher to enter the lived experience of the participant and be an insider researcher, as guided by Heidegger: the role of the researcher is to listen (Smith, Flowers and Larkin 2009).

Figure 1: Interview schedule

Theoretical assumptions	Example interview questions	Prompts
‘being in the world’ (individual self)	<i>‘Can you please tell me what it is like being a SP?’</i> <i>‘What does it mean ‘to be’ a SP?’</i> <i>‘How would you compare with?’</i>	<b>Interview</b> ‘tell me about that....’ ‘can you describe?’ ‘can you think of an example?’
Fore conceptions (values and decisions)	<i>‘What do you value about your role as SP?’</i> <i>‘What does it mean to you to be a SP?’</i> <i>‘What knowledge were you using?’</i>	‘who might have said that?’ ‘what did you do?’ ‘what would that be like?’
‘time’ (lived experience)	<i>‘Can you please give me an overview of your caseload and practice population?’</i> <i>‘What knowledge and skills do you use?’</i>	<b>Audio-diary</b> What happened here and was it successful? What was it like for you? What specialist knowledge, skills and attributes did you use?
‘context’ or ‘space’ (occupational ideology and cultural knowledge)	<i>‘What’s it like working with.....?’</i> <i>‘What are your thoughts on all the changes that are happening?’</i> <i>‘What does it mean for you that the role is changing?’</i> <i>‘What is the impact of perceived lack of value of the role?’</i>	What difference do you think your status as SP made to patient care in this situation? What contextual factors enabled or prevented you from carrying out your role?

The research questions are answered through analysis in IPA studies (Smith et al. 2009). Following interviews, participants were invited to keep an audio-journal, in order to achieve a holistic view of the phenomenon. Audio-journaling suggested by Nicholl (2010) was encouraged for at least 5 days as a complementary method of data collection to get further insight into the phenomenon. This opportunity to blend personal reflections, accounts of events and descriptions of experiences was intended to provide access to participants' interpretations of their worlds (Alazewski 2006). Participants were asked one question designed as a prompt: *'Can you please describe situations where you used your specialist expertise and attributes?'* Two participants kept a journal for 6 days, five for 5 days, and one participant opted not to keep a journal. Interviews and journals were transcribed verbatim by the researcher. Confidentiality was ensured by both participants and the researcher. Audio-journals, data recording equipment and subsequent data were kept in secure locations.

Ethical approval was granted from a University Ethics Committee [REP 00790] and Research and Development Approval was granted by the participating National Health Service Health Board [GN12CH4636 180413]. The study was conducted in accordance with the principles set out in the Health & Care Professions Council (HCPC) Standards of Conduct, Performance and Ethics (2016).

### **Data analysis**

Figure 2: Process of IPA

Step 1: Reading and re-reading
Step 2: Initial coding
Step 3: Developing emergent themes
Step 4: Searching for connections across emergent themes
Step 5: Moving to the next case
Step 6: Looking for patterns across cases

Smith et al (2009)

IPA is an inductive method of data analysis that requires close attention to the detail of descriptions provided by individuals. The researcher aims to derive an understanding of participants' subjective experiences (Smith, Flowers and Larkin. 2009). The IPA framework adopted (Smith, Flowers and Larkin 2009) (Fig 2) describes a set of principles that are inductive and iterative, cyclical rather than linear. The intention is to enter a dialogue with participants through the data, gaining increasing levels of insight through multiple levels of analysis. The process enables movement from description to interpretation. This process is committed to understand meaning for each participant within their own context, as well as shared meaning (Reid, Flowers and Larkin 2005). Each participant's interview and audio-journal transcripts were analysed simultaneously. For the present study, the data were coded for participants' descriptions of expertise with all passages that referred to expertise being selected out for closer analysis. This process was conducted inclusively so as make available for close inspection all material of relevance to this study. These passages were then read and re-read in order for the researcher to become familiar with the data. By reading and re-reading transcripts, initial themes generated from exploratory to conceptual coding. This occurred by paying attention to description and content of participants' dialogue, as well as verbal and non-verbal language used. Analysis thereafter turned to identification of indicators of meaning within the data. These indicators were then clustered into emerging themes which in turn were constantly compared across all transcripts in the data set and further developed. Any instances that initially appeared irregular from the emerging themes were examined in detail. This analysis continued on an iterative basis until no further themes emerged and the themes that were derived provided best analytic fit with the participants' own descriptions of their experiences. Coding examples of

individual data is presented in Fig 3. Data were initially analysed by the first author and thereafter analysis was discussed and agreed by all authors.

Figure 3: Coding examples

Initial Coding examples		Example quotes		Subthemes		
<b>Participant 001</b> Building a therapeutic relationship Adapting to the context of community Seeing the bigger picture Evolving clinical role Responsibility Leadership vs management Staff development		<b>Participant 001</b> It's only me, I carry the can  Developing others creatively  Just saying, 'you're not alone'		Being but not being perceived as specialist  Negotiating time to care		
<b>Participant 006</b> Breadth of nursing knowledge Considering the whole picture Bureaucracy of assessment Responding to needs and expectations of patients and families Challenges of working together Enabling others to find solutions Responsibility Leaders as managers Having courage		Opening Pandora's box  Being seen as the boss  <b>Participant 006</b> Being authoritative  Conductor of an orchestra  Confidence in own abilities  Enabling others to find solutions  Making it work		Managing complexity  Thinking on your feet  Growing into the role		Being expert



There is considerable debate in the literature on the question of quality in qualitative research, and the extent to which the criterion of saturation is relevant to all qualitative work (O'Reilly & Parker 2013). The approach of IPA is explicitly double-hermeneutic, relying on the researcher's interpretations of the participants' sense-making of their experiences. As such, other interpretations of data are always possible and it is more useful to look to criteria of quality other than saturation in IPA studies (Smith et al, 2009). Here we refer to the four criteria for quality in qualitative research proposed by Yardley (2000) and as applied to IPA studies by Smith, Flowers and Larkin (2009). As conducted, the study displayed *sensitivity to context* in focusing on the participants' experiences of being SPDNs, and *commitment and rigour* in the close attention paid to data collection and subsequent thoroughness of analysis. This report of our research is designed to demonstrate *transparency* and *coherence* in conveying the detail of how the study was conducted and the findings derived. The final conclusions of this paper subsequently meet the final criterion of displaying *impact and importance* in providing useful understanding of SPDNs experiences.

## Findings

All participants were female nurses, working in the community (Table 1). They had between 7 and 26 years experience since achieving their SPQ. Six had District Nurse as their role title. Two participants' role title was Advanced Practitioner (AP). They had transitioned from the DN role into a role co-located with a multi-disciplinary team. With a rehabilitation focus, their role was in the main concerned with assessing frail older patients. District Nurse participants had caseloads of adult patients with a broad range of health and social care needs, but with an emphasis on acute care episodes, managing long-term conditions and end of life care. They also

had an additional team leadership role compared with APs who were part of self-managing teams. The sample size was consistent with the idiographic nature of the inquiry, according to Smith et al. (2009).

Table 1: Participant characteristics

Participant	Experience as SPDN	Band	Role	Graduate	Team Leadership	Caseload	Caseload size
Mary	7 years	Band 6	District Nurse	Yes	Team leader: 3F/T & 2 P/T Staff Nurses, 1 Treatment Room Nurse, 1 Anticipatory Care Nurse	Mostly patients with palliative care needs, Long-term conditions and chronic social problems	65+
Jane	12 years	Band 7	District Nurse	Yes	Team leader: Co-shares caseload with Band 6 4 Staff Nurses	Mostly patients with palliative care needs, Long-term conditions; young adults with learning disabilities	70-80
Ali	23 years OOHs	Band 6	District Nurse	Yes	Team leader: 3 Staff Nurses, 1 Enrolled Nurse, 1 Healthcare Support Worker (HCSW)	Affluent area, frail older people on caseload. High degree of social isolation,	87
Katherine	13 years	Band 6	District Nurse	Yes	Team leader: 1 Staff Nurse	Area of high deprivation and associate complex health problems	Approx. 45

Jo	26 years	Band 6	Advanced Practitioner	Yes	Shared leadership: Older People's Rehabilitation Team – multi-disciplinary with administrative support	Older people with rehabilitation needs. Emphasis on assessing patients whose condition is deteriorating	15-20
Denise	8 years	Band 6	District Nurse	Yes	Team leader: 7 Staff Nurses 1 HCSW/ phlebotomist	Mix of affluent and deprived area. High numbers of patients with palliative care needs	101
Fay	8 years	Acting Band 7	Advanced Practitioner	Yes	Shared leadership: Older People's Rehabilitation Team – multi-disciplinary with administrative support	Affluent area, frail older people requiring rehabilitation. Emphasis on assessing patients whose condition is deteriorating. High degree of social isolation and 'hard to reach' groups.	200-250
Steph	13 years OOHs	Band 6	District Nurse	Yes	Team leader: 2 P/T Staff Nurses	Affluent area, frail older people, patients with complex needs due to	50

						long-term conditions. High numbers of patients with palliative care needs.	
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Before considering the themes that emerged from the analysis, it is interesting to note that throughout the interviews and audio-journals the participants referred to themselves as ‘sister’ or ‘Band 6’ (organisational pay banding) and not as Specialist Practitioners. Despite identifying with the DN role, they chose not to refer to specialization within their role titles, nor did they appear to perceive they were viewed as ‘specialist’ by colleagues or management. All participants described a sense of authority. DNs appeared to place little value on their ability to be creative in ‘*finding solutions that keep patients at home*’ (Ali), in ‘*anticipating problems*’ (Steph) and doing ‘*when there isn’t anyone else to do it*’ (Jane) despite emerging in the data. Participants described their expertise in terms of three themes, namely ‘*negotiating a ‘way in’ to care*’, ‘*managing complexity*’ and ‘*thinking on your feet*’. These are considered in turn below.

### ***Negotiating a ‘way in’ to care***

Each participant described how they established personal relationships of trust with care recipients so they could provide support and be care-givers. Irrespective of the communities within which they practiced, they highlighted the need for negotiation as a foundation of caring. They described taking time in establishing and maintaining trusting relationships, allowing them to elicit patient and carer expectations of the service and identifying their needs. Fay described ‘*use of self*’ in building relationships with people in ‘*hard to reach*’ communities with a distrust of care professionals, whilst Ali described being a stranger in patients’ homes and having to

negotiate care giving, to address sensitive care needs. Steph's account related a sense of seeking permission to care and having to negotiate 'a way in', enabling her to work out priorities:

*'Sometimes it's hard for people when they've just met you. Sometimes they will tell you everything and other times they won't tell you very much, so I wouldn't push it. [ ] I try to go on the cues of the patient, so sometimes your assessment might be a ten minute thing and sometimes an hour, just to see what's going on'.*

All participants alluded to their communication skills being at an 'advanced' level, including skills of 'listening' and 'being with' (Katherine), gaining knowledge of the patient and the context. They used this knowledge in decision-making to 'understand the goals of care' (Steph), 'their patterns of behaviour' (Katherine), 'symptoms and coping strategies' (Ali). The metaphor 'doing the dance around' was used by Steph as an illustration of how she used skills to find out patients' and carers' understanding of their situation, their needs, wants and expectations. The intention of negotiation appeared to be to reach shared decisions and enable patients and families to self-manage.

In this study, psychological caring for patients and families who were distressed, was characteristic of participants' expertise and a means of 'finding a way in' to meet other care needs. However, time appeared to be a mediator of care, a particular issue of DNs, whose team management role had an impact on clinical time. Participants described situations where patients were transitioning through stages of grief and loss, requiring support to achieve acceptance. This was particularly evident in caring for people at the end of their life and was illustrated by Jan:

*'I've just finished a visit with my palliative patient, I've been in there for the last hour or so.....em this lady had quite a bad weekend obviously with her symptoms and I think the biggest one for her is the actual fear and slight denial as well of this so I've just spent most of the time sitting just listening to her concerns and answering her questions as best as possible as I can.'*

Extending psychological caring to carers also emerged as a significant part of work. This was powerfully presented by Steph where a carer was not coping with the rapid deterioration in her husband's condition and the implications for his safety:

*'He's effectively dying [ ] we're having to sit down and have some pretty frank discussions with them ..... We have tried to broach it with them and they shut us down, they just didn't want that conversation to be had. But the problem is we're coming in to his safety'.*

This illustrates the need for ongoing negotiation and therapeutic use of self, finding ways to make care acceptable to patients and families as they attempt to continue with life as 'normally' as possible. The need for time to enable patients to manage their own care was highlighted by some. However, Ali suggested the time needed was not always taken, creating dependency:

*'We make patients dependent on us rather than promoting independence....I think we do have a culture of allowing patients to depend on us'*

### **Managing complexity**

The complexity of care management is characteristic of the DN role, although there was wide variability in language used to illustrate this. Many participants described being able to '*see the whole*' or '*the bigger picture*,' although visiting for a '*supra-pubic catheter*,' '*palliative patient*' and '*wound care*' were phrases that appeared contradictory. Complexity appears to be concerned with application of layers of knowledge: contextual, propositional knowledge and professional knowledge which make up their professional craft knowledge. Their use of these layers of knowledge enabled them to take a proactive approach to caring, anticipating a range of care needs.

Contextual knowledge is concerned with the context within which the care is delivered and particularly concerns the context of the community, the caseload and the family. All participants alluded to their knowledge of the community, the population needs, enabling them to signpost and access a range of services to support patients and families. Denise emphasised how knowledge of their caseload and available resources was necessary to make care decisions. They also highlighted legal frameworks within which they work, particularly mentioning Adult Support and Protection legislation, alerting them to issues of vulnerability during assessment. Steph also gave an example of working with the Liverpool Care Pathway (since withdrawn in UK), which enabled her to anticipate palliative and other care needs and be proactive, ensuring appropriate conversations took place with patients and families. This enabled her to inform the extended team and make sure relevant documentation was placed in the house e.g. Verification of Death, DNAR orders. The sensitivity, compassion and care was perceived to be part of their autonomous practice.

Using knowledge of the patient and families,' their coping strategies and patterns of behaviour were highlighted as intentional strategies of establishing relationships and negotiating caring. Participants also alluded to the importance of making patient and family needs explicit in order to work together for defined patient outcomes. They highlighted ill-defined patient and family outcomes and needs that risked creating tension between respect for patient autonomy and risk assessment. Participants suggested this added significantly to the complexity of care giving. Also carer involvement was highlighted as a factor of complexity, '*because you can't deliver all the care*' (Katherine). Pandora's Box was a powerful metaphor used for the complexity of care management:

*‘You’re not just treating the patient. That person lives 24/7 – they are taking on the bulk of the role [ ] sometimes you open a Pandora’s Box when you tap in like .. ‘Ok you live with your son’ but it maybe turns out like your son is taking your money he’s not doing this for you and then you have to go to the social work and it just gets bigger and bigger when you think looking on that bit of card it just says go and visit the leg ulcer and treat it..... It’s just that leg ulcer might take say 10% of your focus but let’s get everything that’s caused this and round about it’ (Mary)*

*‘[a visit] ....opens up a Pandora’s box of all the other things I need to go and do which can require the management skills of case management.... ‘Who’s seeing the patient?’ ‘Who do I refer to?’ ‘How do I coordinate that?’ ‘How do I make sure that once I’ve coordinated that it happens?’ It’s the follow on that then makes it happen’ (Jane).*

Their professional craft knowledge also was propositional knowledge. They applied this within the context of the home and participants described their communication with patients and carers as being delivered in ways that were accessible, demonstrated empathy and offered reassurance. In an example given by Katherine, she explained her approach, compared with an outreach hospital nurse specialist. She perceived that the Clinical Nurse Specialist (CNS) dressed a patient’s burn, focusing on the wound care task. She perceived the CNS’ assessment did not consider the patient’s pain which was inadequately controlled. This was impacting on how she was able to live her life at home, but Katherine felt this was not adequately assessed, nor managed:

*‘ .....keeping the patient the centre of everything and taking that whole home environment.....it wasn’t just the wound, it was the fact that lady couldn’t get up and down the stairs .It was to do with the fact that she was eating but still losing weight [ ] what I actually apply is my knowledge, and my, what I’m doing is applying my analytical skills to that situation and I’m finding myself in with that patient’*

Being able to pick up subtle cues from the patient, the family and the environment was a distinguishing feature of their professional craft knowledge. This professional knowledge enabled them to undertake assessments that constantly evolved. They were described in a number of ways: *‘let the patient tell their story’* (Jane) paid attention to, *‘wee triggers that go off in the house’* responding by *‘scratching beneath the surface’* (Mary), Family dynamics,



psychological and other welfare and social issues are characteristic of their assessment (Jane & Ali). Fay expressed this as, *'being like a detective'*. Participants described their knowledge as 'deeper,' 'an extra layer' and 'broader than others, less expert. Knowledge of evidence-informed cancer and palliative care for example, enabled Mary to give reassurance by explaining what care options might be, should a range of sequelae occur. These sequelae, considered for individuals within their particular home context and are aimed at avoiding unnecessary hospital admission. They inform decision-making and care management and require a range of interventions. A number of participants care management included being able to make prescribing decisions. Mary described how her pharmacological knowledge enabled her to outline for the patients options for anticipatory prescribing.

Participants perceived their knowledge provided reassurance, symptom management and enabled anticipation of ongoing care needs. Being the one to *'follow through'* (Jane) was related to how they managed responsibility. Jo described how her knowledge enabled her to assess, treat and evaluate care for a patient without involving the GP:

*' .... during my medication review I realised that [patient] should be taking a course of steroids but she hasn't so I've now prescribed that course of steroids for 6 days because she had creps in her chest when I was listening and hopefully that will improve her chest and I'll review her in a weeks' time'* (Jo)

She also described joint decision-making about treatment with GP colleagues. Such knowledge also enabled being proactive in diagnostic testing and effective teamworking with GPs. Participants suggested confidence in their decision-making. It also enabled them to participate in decision-making at a distance and delegate appropriately.

## Thinking on your feet

The third theme refers to having fast reactions and having the ability to find relevant cues from a range of information in order to identify patient and family's needs and potential solutions. Being flexible and able to be creative problem-solvers were characteristics of their role. This is due to unpredictability of situations. Jane described a range of situations where potential crises could occur:

*'When they're [patient] in a bed you know what you're getting. You walk in a front door of a patient's house you've no idea what you're getting and even if you know that patient 50 times you still don't know what you're going to walk through the door to like...a dead patient – you know a critically ill patient, a relative who you think .....oh my god I'm feeling threatened, I need to get out'*

Fay, described a situation where immediately she felt on her guard as her intuition was that something was not right in a patient's home. She outlined how she immediately tuned into the environment, picking up cues before seeing the patient. She described *'her senses were ablaze'* picking up visual cues like uneaten food, equipment, state of cleanliness or disrepair; temperature; or of odours indicating issues which may include cognitive or physical impairment or illness.. She reported that this assessment alerted her to potential crises and enabled her to respond quickly. Steph also illustrated how she used sensory cues in the steps of her decision-making in a similar situation:

*'I think first of all I look at the situation and I rationalise it down to key points so that I can evidence my decision-making and then a lot of it is almost on your nursing intuition..... [ ] You're casting an eye on someone over years of working with palliative patients, you know when they are starting to deteriorate, you know you can spot the signs and symptoms. You know she*

*was losing weight at a rapid loss. Every time you saw her she was absolutely skeletal. She always was a thin lady anyway but you could tell, she was getting weaker. She wasn't sitting as well in the chair. She was struggling more, she was waiting for you to help her get out of bed. You just pick up on wee bits and pieces – cues that they are saying to you and the way they communicate with you. Sometimes they are waiting for you – you know they drop you the hint so they can give you the cue and you can say something back and do your dance around ...'*

Ali described a situation where a lady with learning difficulties was agitated and refusing medication for hypertension and tachycardia. She had a history of refusing hospital admission. The way Ali engaged with her was helping her with some untidiness, whilst making an assessment of her physical needs. She was then able to encourage her to take her medication. Other examples offered focused on social care needs and the immediacy of involving other care practitioners. Ali cited the example of a husband who was a carer being taken into hospital leaving the family unable to cope and in potential crisis. As the gentleman's wife was vulnerable, Ali described having to identify a range of options quickly. Engaging with their daughter, she reported::

*'I involved a social worker. Sat with the daughter who admitted she really couldn't cope with her mother being unwell. Her father being in hospital is the main carer for her mum ..... finally agreeing, yep they would take services. I coordinated that.... got it together. It took a lot of effort and it ended up subsequently the lady had to have emergency respite to a nursing home ..... One of the [staff nurses] comments was, 'why don't you just get her admitted to hospital? Oh, cos she's not ill, it's the husband that's ill... '.*

Ali's knowledge of community services helped her to problem solve and her ability to coordinate care made things happen quickly. Denise also used her knowledge of the community to enable her to make an assessment of risk when she was asked to visit a patient with a violent background with a history of substance misuse. She was aware of this from experience. Her risk assessment took into account the wider inter-agency team delivering care and involved communicating to colleagues working in and out-of-hours.

## Discussion

The findings demonstrate the three themes of greatest importance to the participants in making sense of nursing in the community and the role of expertise within that. To some extent, participants' understandings may reflect the use of existing definitions of expertise identified in previous work. For example the finding of expertise in the theme *negotiating 'a way in' to care*, could reflect the ability to draw on a wide range of knowledge (Schunn et al. 2005; Kotzee 2014) or professional craft knowledge (Manley, Hardy, Titchen, Garbett, and McCormack 2005). *Managing complexity* might appear to reflect the use of highly-developed reasoning strategies (Boshuizen & Schmidt, 2008) or professional artistry (Manley, Hardy, Titchen, Garbett, and McCormack 2005). Similarly, the theme of *thinking on your feet* could perhaps be viewed as linked to nursing as a model of practical action (Benner 1984; Rolfe 1998). Indeed elements of these themes potentially might be linked to various previous conceptualisations of expertise, providing some support for many of the versions of expertise found in the literature over the last 30 years.

However, to view the participants' accounts as straightforwardly reflecting theoretical interpretations of expertise is largely to miss the point. For, what our findings point to is the dynamic, contextualised and action-oriented nature of expertise required of nursing in the community. The themes identified here do not readily map onto cognitive skills and structures, reasoning strategies or other attributes that are internal to the participants. Rather each theme comprises action in the environment, the idea of '*being-in-context*' (Heidegger 1995; Gadamer 2004; Smith and Osborn 2008). Thus, *negotiating 'a way in' to care* requires participants to create the environments within which they can provide care, *managing complexity* involves

deriving solutions to problems with multiple external variables, and *thinking on your feet* involves the co-ordination and response to situations that comprise a diverse range of medical, psychological and social needs requiring immediate attention. Each of these themes therefore refers to more than the recall and application of cognitive knowledge and abilities or the use of particular forms of reasoning; instead each theme reflects nursing in the community as action in an altogether more contextualised and holistic manner. The considerations of expertise derived from our data do in one sense appear to encompass forms of expertise that are based on intuition and that therefore might be more difficult to articulate (Benner, 1984) or that are tacit or opaque (Meerabeau 1992; Herbig, Büssing & Ewert 2001). It is however interesting to note that our participants did indeed articulate this dimension of expertise. This, we suggest, demonstrates the utility and value of using IPA, the approach adopted in the present study. Whereas work focusing on the identification of knowledge and skills is *a priori* likely to find these attributes within the individuals involved, the framework of IPA is designed to allow for a more nuanced and dynamic understanding of nursing as actions that involve nurses and communities in context.

What these findings point to, is the importance of understanding the dynamic nature of the expertise that community-based nurses use in delivering care in such settings, whether as SPDNs in the UK or working in communities elsewhere across the globe. Rather than being an identifiable set of specialised skills that can be readily applied when needed, expertise reflects engagement with all aspects of the setting in which nursing is provided in order to deliver most effectively the service called for by the WHO (1999; 2013; 2016). We assert that those coming to nursing in community settings need to be able to learn from those who have acquired such expertise (WHO, 2010). This clearly will be challenging in contexts where recruitment of

candidates and retention of those with community-based expertise are difficult. Nonetheless, findings such as these indicate the importance that those working in nursing attach to community-based expertise and may inform education curricula and the ongoing discourse about community nursing roles.

## **Conclusion**

These findings demonstrate the challenges that the SPDN profession in the UK currently faces: first, participants in describing their experiences made no reference to specialisation or to themselves as specialist practitioners and, second, their descriptions of their experiences of practice all indicate the extent of the actions with which SPDNs need to engage in order to deliver nursing in the community. The findings provide insights into the role of expertise within the community nursing workforce internationally and may contribute to discussion around service review and development. In the UK specifically, the absence of recognition, or perhaps perceived relevance, of the professional title which is linked to educational provision, potentially might make the role title of specialist practitioner one that is mis-representative of the professional group. However, across the world, care is being delivered in communities, arguably the context being the specialism. The findings of this study therefore have relevance beyond the UK and will contribute to the evidence around expertise of nurses working within these contexts.

## **Relevance to clinical practice**

These findings provide insights into the expertise of community-based nurses in the UK and the importance of maintaining an effective and engaged SPDN profession. They also point to the importance of recognising community-based expertise on an international level, especially if

current WHO aims for community-based health care are to be achieved. Understanding expertise will add to current community nursing discourse and may make a contribution to current service reviews and policy implementation. Further insight will have relevance to educators. Specifically, what are most needed are curricula that equip nurses to meet the challenges they will encounter in community settings across the globe.

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